Section 5. The stories doctors told
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The temptation (is) to regard goals as near when they are in fact far, assured when they are merely wished for, and achieved when they are at best approximated.

(Geertz)[44]

The complexity and unpredictability of the learning process is well described by the above quotation. Understanding this uncertainty is critical to intervening to support it more sensitively. The stories that doctors told illuminate what the educational process and its uncertainty mean for Balint groups. Many of the lessons learned and insights gained are more generally applicable to small-group work. As we examine the stories that doctors told, we identify what appears to work well, what needs reconsideration and perhaps change. More significantly, we endeavour to extend the debate about Balint and small-group work to support future development.

The case studies presented and the data gathered point to the ways in which individual doctors engaged with the learning process. This section explores the educational implications of the lessons embedded in doctors' narratives.

Our discussions of method (case study), methodology (ethnography) and concepts (narrative) have examined a logic (indeed an epistemology, a way of knowing) that enabled the different and, at times, contradictory, dimensions of the doctors' narratives to be identified. We found that doctors' stories:

- Were conservative as well as potentially liberating. They were learning established and contemporary professional attitudes and values as well as challenging them.
- Could best be understood in context. It was understanding their context that enabled us to understand the meaning their stories had for themselves and their groups. Understanding the context also enabled us to glimpse how some professional perspectives were shaped and professional realities created.

Understanding what people mean by what they say is only part of the challenge facing those seeking to identify learning processes in action. Meaning was not merely a language issue; it was also a social and cultural issue. Personal meanings are socially embedded, and understanding the relationship between the two can facilitate change. Below we take a closer look at the learning process in action and its potential.

Our analysis proceeds under the following headings:

- An outline of context
- New stories, new thinking
- Silencing stories
- Mistaking cultural identifiers for culture
- Caring for others: a moral tale
- Supporting each other, caring for themselves.

Summaries of the findings are provided in the boxed text below.

An outline of context

Much was happening in the groups. Through storytelling, group work gave doctors the opportunity to air absorbing and sometimes painful dilemmas from everyday practice and to draw on others' ideas, taking occasional risks in doing so. It provided an arena in which to develop a more sensitive understanding of their patients and to suspend judgements while feeling supported – despite a professional climate that undervalues the inner life. Importantly, this was a departure from more mechanistic approaches to learning, enabling doctors to find their moral bearings in an unruly world. Exploring experience invited the doctors as individuals and within groups to learn about individual patients and themselves, while providing care. The complexity of the endeavour was unravelled with each experience, case by case. In questioning the quick-fix mentality of much medical practice, a balance more appropriate for general practice was being suggested between 'being' and 'doing more'.

For some doctors, this kind of small-group experience was not new. These small groups reinforced the value of individuals examining their own experiences and sharing that with peers. However, it is important to distinguish the 'is' from the 'what ought to be'. Whilst group work was an educational experience all round, more elusive was the question of what had actually been learned.

> Small groups provided the opportunity for individual doctors to examine their experience, the messiness of it and their complex and contradictory reactions to it. Though participants valued sharing their experiences within a group, their learning was not identifiable as a series of established outcomes. Rather it appeared to reside in the more elusive terrain of forming a professional sense of self in practice.

New stories, new thinking

In many ways the stories told within the group were liberating, opening GPs' eyes to new ways of thinking about the doctor–patient relationship. The course organisers' invitation in both groups to explore *'what's going on here'* encouraged their imagination to roam beyond the familiar confines of the biomedical model, a process enhanced by imaginative leadership in both groups. At Highville there was frequent reference to how *'Balint is not about thinking in boxes'*; *'the discussion time that's very rich for me'*; and the pleasure *'of all these new ideas'* (Case 6). In *'thinking the unthinkable'* with her ethics training case, Dr Sanju found a rich resource for

questioning some assumptions. At Jamestown, too, Dr Norton was discovering deeper aspects to her work not covered in textbooks. Imagination is different from knowing how, or knowing what. It is more akin to a third way of knowing.

Attention to detail, a feature stressed in Balint groups, opened a window on the patient's world that was previously opaque: the Somali patient who might be neglecting her pregnancy in revenge for an abusive husband (Case 7); Dr Lytton's compatriot who had overstepped the limits of the Western healing relationship (Case 1); or Dr Plaidy's attempts to widen the group's perspective about the roughage-hunting young businessman (Case 7). The follow ups doctors brought to Highville each time indicated the search for more grounded understandings. The depth of coverage, disciplined speculation and time allowed for each case encouraged at Highville was also a source of inspiration for some doctors, marking the learning experience off as qualitatively different (Case 4).

At the same time, stories are inherently conservative. They thrive on what is already taken for granted, inevitably reminding people of similar cases just like it. In talking about their patients to the group, doctors were 'giving a flavour of things', sifting and selecting, with an eye on their audience. The results were not accidental, but embedded deep within the professional culture in which they were finding a home. It was a case of doing old things in new places.

Unsurprisingly, therefore, many of the stories in the groups had similar plots. *'Surprising how many cases are about patients who don't do what we tell them'* noted one practitioner at a Balint leaders' workshop. Richly varied though they were in detail, *'the patient who puzzled'* slipped through doctors' fingers in customary ways: the patient who came in with *'too many'* or *'inappropriate'* problems; the difficulties of handling extended families in the consulting room; anxieties with interpreters from the patient's own family; the patient (or doctor) who came too close for comfort. Their power derived from their very familiarity: the attempt to impose order and predictability upon the untidy world of general practice. How much of the tidying was necessary for daily survival in practice? Would there be inherent dangers in constant tidying, a progressive blindness of aspects of the doctor–patient relationship that needed at least occasional scrutiny?

> The stories told, and the imaginative group facilitation of those stories, opened new ways of thinking about the doctor–patient relationship, well beyond a biomedical model. Yet these new stories had their own conventions and limitations. Patterns emerged, providing a consensual and contemporary storying of the doctor–patient relationship. It may have enhanced the learning process if these new assumptions and values had been identified and discussed.

Silencing stories

Not all the stories that could and, perhaps, should have been told, were told.

The stories that are *not* told are often as important as, if not more important than, the ones that are. In providing an arena for the narration of some stories, much was not said. Unlike Jamestown, Highville wasn't the place to discuss practice difficulties or tensions with a trainer, situations that often trouble young doctors. Some registrars wondered why. Such topics were likely to be awkward for reasons other than Balint's traditional concentration on the doctor–patient relationship, as Dr Fitzjohn's group indicated. Neither could the interesting detour necessarily be pursued. In finding their spontaneity circumscribed (*'I do find it difficult being* so *directed'*) doctors were upset when the choreography prevented them from correcting any misunderstandings that had arisen. Anxiety about being misinterpreted was rife; the words found were not always the words meant.

It was also difficult to know how far the group work philosophy itself could be directly questioned. *'Why can't we take people at face value?'* asked Dr Naroo. When interviewed, some doctors queried the balance between *'teaching and the spontaneous stuff'*; this was a tension that surfaced at Highville and was quickly repaired (Case 7). Any resistance was along familiar lines: *'Where were the facts?'* Speculation seemed to be within the frame rather than questioning the frame itself. A persistent worry concerned the limits of tolerance. Was there a place within group work for genuine disagreement to be respected, to see difference as a means to personal growth rather than a threat? Importantly, what was a norm in this context, and how should one go about imagining it?

> An exclusive focus on the doctor–patient relationship could obscure other issues that troubled junior doctors. This focus, held through facilitation, is one example of how subtle forms of direction prescribed what could be said. Amid the openness was a process that implied what appropriate professional attitudes were and that shaped what could be discussed.

The following section provides a good example of the unseen parameters around what stories could and could not be told – at once a source of strength and protection as several doctors at Highville were quick to point out.

Mistaking cultural identifiers for culture

The primary focus of the biomedical model of medical education does not equip doctors to deal with the complex social dimensions of caring for patients. Dealing with the diversity of patients' lives, often reflecting their culture of origin, is a daily part of the role of the GP, as the doctors' stories illustrated. Many stories centred on this theme: *'the Egyptian patient'* in Case 3; the Bangladeshi patients in Case 4. Understandably doctors were perplexed when their patients in temporary accommodation turned down *'suitable housing offers'* or brought in social security forms for them to authorise.

The more traditional one-to-one image of the doctor–patient relationship was confounded when patients brought a train of relatives into the surgery. Where did the patient end? Who decided? The separation of mind and body from 'the social and cultural' had already done its work.

Yet *'understanding context is part of your work too'* noted the psychotherapist at a Balint leaders' workshop. If the patient was to be understood holistically, doctors could not avoid Dr Malek's injunction to situate the individual patient *'within their family and their community'*. Not surprisingly it was one matter to appreciate intellectually the risks of imposing Western concepts of autonomy and choice on patients from different ethnic backgrounds, and quite another to grasp that *'taking responsibility for your health'* may have different meanings for patients who see their obligations as more relational. Learning what goes without saying meant learning a new language metaphorically as well as literally, as the registrar working in a deprived Turkish community was discovering. What did the small gifts often offered mean?

Whilst doctors prided themselves on their openness to each other in the group, the mufflings and evasions spoke eloquently of the difficulties of doing so in practice, as Drs Ling, Lytton and Malek indicated at interview. Such reticence both reflects – and is likely to reproduce – wider tensions between the public acceptance of diversity and the private distancing from it that so vexes our age. 'Ethnicity' (or 'culture' in the narrow sense) wasn't the problem. Different perspectives allowed a glimpse of culture in its wider sense, revealing assumptions about the nature of the Self not often questioned in psychoanalytical teaching. Some stories were not for the telling, even in Balint groups. What effects had this silent censuring on how doctors thought about themselves as professionals, and their patients as individuals with widely differing backgrounds, assumptions and needs? What was the hidden curriculum here, the un-sayable and, perhaps, the un-challengeable norms and assumptions of practice?

What do the silenced stories reveal about the contemporary professional view of the doctor–patient relationship? Unsurprisingly, dealing with the humanity, diversity and social expectations of patients remains a challenge. Silenced stories reflect lingering, and perhaps changing, professional expectations of the role of the GP, and suggest limits on what is regarded as appropriate to demand. Identifying and exploring silences within group narratives might be a useful learning exercise to help doctors consciously develop a professional sense and reflect on the kind of relationship they might strive to have with their future patients.

Caring for others: a moral tale

At the best of times, respect across boundaries of inequality for those in need can often be fragile. In both groups, doctors clearly recognised its importance. Dr Fitzjohn's metaphor about 'wearing another pair of moccasins' seemed to bear some fruit, as Dr Norton's engagement with her learning-disabled patient indicated. The stories have drawn attention to the warm bonds of sympathy often existing between patient and doctor (the patient who approached Dr Malek *'as a niece asking about my family'*; Dr Lytton's responsiveness to the patient from her own background), one registrar recognising such moments as *'one of the beauties . . . the joys and privileges of medicine'*. Doctors spoke modestly of *'compassion'* and *'feeling sorry'* for patients, gaining a nod of approval from Dr Scorso for doing so. Compassion works best when it's not worn on one's sleeve[45] and mostly there was no sting of pity here. The search within could be richly productive.

Focusing on the many consultations that had gone well held out only limited possibilities for understanding. The story that grips the imagination is one that runs counter to expectancy. The tellable tale pivots around trouble.[38] And trouble – *'the patient who puzzles'* – generates strong emotions.

The framing of stories allowed feelings such as *'helplessness'* or *'annoyance'* to be expressed in both groups. Banal as the words were, these were emotion-laden but socially approved ways of talking about patients. The motif *'use it but don't react to it'* formed part of a collectively shared emotional dictionary that helped to shape the contours of what was appropriate to feel, and how it should be described.

Understandably there was considerable anxiety about how to address problems that lent themselves poorly to textbook solutions. *'Where were the experts?'* Dr Caernarvon wondered. A Jamestown registrar confessed at interview how *'irritated'* she was with patients who rang her up to announce their imminent demise, only to find herself nonplussed when one of her patients was as good as her word. The care doctors wanted to give their patients slipped all too humanly into exasperation or resentment when they felt their space *'invaded'*, their waiting rooms *'cluttered with children'* or their valuable time slipping away when patients were *'so* slow!' It was easy to lose sight of the way that it is doctors who have the right to take their time, and other people's, not the other way around. How were doctors to heal – or educate – when their own preconceptions, or those of the system in which they operated, often set them off course?

The emphasis in both groups on deferring judgement was hard to sustain in practice. However sympathetically drawn, patients were caught in the spotlight as well. The task of emotional diagnosis objectified the patients as well as opening a space for human dialogue. *'Bringing the two bubbles together'* did not always sit happily with other metaphors about the patient in play. Was the patient *'the master puppeteer'* (as suggested at a Balint memorial lecture),[20] *'the expert'* (Case 7), or *'the child'* who was unaware of the emotional knots underpinning his or her symptoms? The patient who was *'a pain'* was more often than not a woman. Harder to see was the 'us' in 'them' and the 'them' in 'us' (witness one registrar's recognition of the toll looking after young children on her own had taken on her).

Daily practice is inevitably a moral and ethical endeavour. Encountering the humanity of patients involved doctors discovering their own humanity.[33] It is worth acknowledging that this kind of exploration of practice and self is difficult and at times anxiety provoking. Compassion and caring were encouraged and approved; more slippery and less attended too were seeing and reflecting on what lay behind irritations, frustrations and exasperations.

Supporting each other, caring for themselves

Stories are both *to* someone as well as *of* something. Like stories everywhere, those told in VTS groups relied for their effect on having an audience. VTS groups were simultaneously private and public (subject to group evaluation). How could doctors negotiate between the two in a morally considered way?

In both groups, the stories told encouraged doctors to share vulnerabilities with each other in ways still insufficiently acknowledged in medicine. The doctors' stories and the layers of meaning they held needed time to emerge. At their best the groups allowed doctors to explore their reactions and the meanings of their stories before situations became a mess. It was often liberating to discover that others were feeling unsure of themselves too, a process likely to be accentuated by the depth and intensity of Balint work. This was an energising acknowledgement that bound group members together in common purpose. A strong collective identity was being fashioned and loyalty to the group cemented – a more profound process than can be conveyed by the term 'support'. The group was also a space to air feelings without incurring the potential stigma of needing counselling, as Dr Caernarvon noted. Such encouragement was a refreshing antithesis to the older blame culture in medicine. In contrast with contemporary obsessions with public accountability, the learning space provided here enabled real personal and professional risks to be taken. Most doctors appreciated this and appeared to blossom accordingly. Witness one registrar, complimented for his contribution at Highville over the year, who flushed with pleasure, both at the time, and again at interview.

However, such simpler framings glossed over other triumphs and disappointments. A good example is the way that tact and integrity pulled in opposite directions. On the one hand doctors were proud of their growing ability to *'criticise constructively'*. On the other hand some felt it was better to withhold criticism altogether, lest it expose rifts that the group ideals of complementarity might be unable to hold together. *'You learn when not to do it'* said one. Taking risks is a risky business. Though there was much to gain, conversely, there was much to lose.

On the other hand, there were nagging questions about authenticity. Friendly and polite gestures offer ambiguous affirmation. Could Dr Norton trust the supportive comments she received at Jamestown? A Highville registrar worried that the responses were *'somehow empty'*, and Dr Ling wondered why talking in the group gave so little entrée into what people were thinking. Still others were conscious that moral judgements were waiting in the wings, the more insistently for not being directly expressed, as Dr Sanju indicated. Any gains in the management of emotions might have a price tag. Politeness as a form of supportive feedback has its limits. It creates uncertainty about what is meant and what judgement lurks in the unsaid.

When groups did show their mettle, careful, considerate, honest and straightforward criticism was as hard to give as it was to receive. We were all found wanting. The formal choreography at Highville could not protect either course organiser or registrar from this. Dr Adamson was gently laughed at for talking about *'the mentally retarded'*. More troubling was the young Asian woman doctor who continued to smile in the face of the course organiser's mounting exasperation when she offered alternative medications to her patient rather than analyse what was happening. How did she nurse her hurts?

Displaying one's thoughts and feelings in public is also to discipline them, a process needing no traditional teaching from the podium.[46] Blame and criticism are essential social processes: *'Of course there's pressure'* said one Steering Group member. The social drama of group work was powerful because doctors were both actors and audience, modelling each other's and the facilitators' gaze. Whilst officially there were no rights and wrongs, there were certainly better ways to feel and think, and doctors were not slow to read between the lines. Returning to their practices, they knew better how to act; they could *'try this . . . or that'* with their patients (Case 2). The friendly power that could not be touched or talked to in the groups was one in which most willingly acquiesced. The hierarchy of medicine disciplined, and at times controlled, the focus of learning.

We tell different stories about 'the same thing' to different people, as the interviews suggest. The groups were not about *'letting it all hang out'*, thus leaving doctors with some room for manœuvre. Indeed Balint groups have always been protective of doctors' inner space. Although doctors couldn't reasonably remain in the group without contributing (despite assertions to the contrary), it was a case of disclosing in strategic ways. As Dr Ling noted *'A mask is what we all wear.'* Whilst it is likely that both groups moulded participants in formative ways, culture is not monolithic, and doctors were not simply passive actors. They reflected, criticised, reframed and, as glimpsed in one group, occasionally rejected what they had experienced within the discussion.

> As a learning space, the openness of groups – though valued – was both limited and temporary. This was not a 'free-for-all', adrift from professional values and norms. Judgements were paused, not eradicated, and part of the hidden curriculum was to learn what could be said and what could not. Disclosures were sincere but strategic. With more examination and reflection on group processes, the offer of openness might be better clarified and negotiated.

In this analysis we have endeavoured to identify both the potential and the limits of small-group work in facilitating how individuals and groups can learn about the complexity of practice and the contexts that help shape it. The learning is in pursuit, not of a better model of small-group working, but of greater awareness of, and sensitivity to, how examining experience can be used to challenge or confirm professional norms, assumptions and practices.

We now turn to consider how the learning potential of small groups can be enhanced.